APPENDIX A

GUIDE TO MEDICARE, MEDI-CAL, AND OTHER HEALTH INSURANCE

1. Medicare

Medicare is a federal health insurance program that has no financial eligibility requirements. Medicare provides health insurance for

- People age 65 and older who are entitled to receive social security retirement benefits
- People under 65 who have been receiving social security disability benefits for at least 25 months
- People under 65 with severe kidney disease

Medicare also covers certain former federal, state, and local government employees and certain former railroad employees. You should contact a local Social Security Administration office to find out whether the conservatee is eligible for coverage.

There are two kinds of Medicare plans: Original Medicare, which is a fee-for-service plan, and Medicare + Choice plans, which include managed care (HMO) plans and fee-for-service plans.

Original Medicare is divided into two parts. Part A (hospital insurance) pays for inpatient hospital services, very limited skilled-nursing facility care following

hospitalization, some part-time home health services, and hospice care. Part B (medical insurance) covers doctor's services, some outpatient services, home health care, diagnostic tests, and medical equipment. Find out whether the conservatee is getting Part A, Part B, or both, by checking the conservatee's Medicare card or by asking the local Social Security Administration office.

CAUTION This section of Appendix A provides a brief and convenient summary of Original Medicare benefits. For more thorough coverage of the federal rules governing these benefits, as well as coverage that may include recent changes not reflected here, check with your local Social Security Administration office for the current booklet on Medicare benefits.

A. Original Medicare Part A: Inpatient Hospital Services

Original Medicare Part A covers inpatient hospital care, very limited skilled-nursing facility care, home health visits, and approved hospice care.

Hospital insurance Hospital benefits apply to a single benefit period that starts when the patient enters a hospital. A new benefit period starts if the patient goes into a hospital again 60 days after being released from a hospital, skilled-nursing facility, or rehabilitation facility.

The number of benefit periods a person can have is unlimited. However, within a benefit period, the maximum benefits are 150 days of inpatient hospital care and up to 60 *lifetime reserve* days that can be used only once.

In 2002, during the first 60 days of hospitalization in each benefit period, Medicare hospital insurance pays for all covered services after the patient has paid an $812 deductible and has paid for the first three pints of blood used (or friends or family members have donated three pints of blood). For day 61 through day 90 of covered care in a benefit period, the patient must pay $203 a day for all covered services, and Medicare pays the rest. For day 91 through day 150 of covered care in a benefit period, the patient's share of covered services increases to $406 a day. After 150 days, the patient must pay the entire cost of the hospitalization.

The average hospital stay for a Medicare recipient is seven days. Therefore, it's highly unlikely that Medicare benefits will be exhausted in any given benefit period.

Nursing facility care Up to 100 days of skilled-nursing facility care are covered by Medicare. The patient must make a co-payment of $101.50 a day after the first 20 days. Medicare covers care in a nursing facility only when the patient is there as a result of the same condition that he or she was hospitalized for. The person must enter the skilled-nursing facility within 30 days after a hospital stay of at least 3 days. If Medicare covers the stay, the average covered period is about two weeks. Medicare pays only for *skilled-nursing care* in a nursing facility. It doesn't pay for what it calls *custodial care,* such as feeding or help with bathing, walking, dressing, or using the toilet.

Home health care Home health care is covered under Part A when it is *medically necessary,* the person is homebound, and a doctor has ordered skilled care and rehabilitation. It can be covered under Part B if the beneficiary doesn't have Part A coverage. There are no deductibles or co-payments. However, a home health agency must make the request for coverage after it receives a doctor's order. The patient must pay 20 percent of the Medicare-approved cost of durable medical equipment used at home.

Hospice care Hospice care is provided if the doctor certifies that the person is terminally ill and is expected to live less than six months. There are no deductibles or co-payments for this care. However, there is a $5.00 co-payment for outpatient prescription drugs and 5 percent of the Medicare-approved cost of respite care. Hospice care provides treatment to relieve pain and supportive services to maintain the patient at home, in a hospital, or in a hospice.

Paying the bill for Part A services Hospitals, skilled-nursing facilities, and home health agencies use insurance companies, such as Blue Shield of California, to send bills to Medicare. Different companies are used for different regions.

B. Original Medicare Part B: Medical Insurance

An individual may enroll in Part B of Original Medicare if he or she is

- Entitled to hospital insurance under Part A

  —or—

- Meets Medicare's U.S. residency requirements

A person enrolls by applying in writing or by showing that he or she is entitled to social security benefits or Part A hospital insurance. Contact a local Social Security office to find out how to apply for the conservatee.

Find out whether the care the conservatee needs is covered by Medicare Part B. This insurance helps to pay for the following:

- Physician's services, including diagnostic and laboratory tests. Other services performed in a doctor's office are covered, such as x-rays, drugs that can't be self-administered, physical therapy, and speech pathology.
- Ambulance services.
- Prosthetic devices and artificial limbs.
- Medical equipment such as wheelchairs and hospital beds.
- Medical supplies, including surgical dressings and casts.
- Home health services that meet certain conditions and that are provided by an agency that participates in the Medicare program.
- Drugs needed during the first year after organ transplants, called immunosuppressive drugs.
- Outpatient services that are provided by hospitals that participate in the Medicare program.
- Other services, including some chiropractic and podiatric services.

Part B medical insurance doesn't cover nursing home care, prescription drugs, most eyeglasses, dental care, hearing aids, or routine examinations.

Paying the bill for Part B services Part B claims are processed by private insurance companies that administer Medicare claims.

In general, Original Medicare Part B pays 80 percent of the *reasonable charges* for all covered services, and 50 percent of the reasonable charges for outpatient mental health care, after the patient has paid a deductible each year ($100 in 2002). People enrolled in Medicare Part B must pay monthly premiums. These premiums usually come out of the recipient's social security check. In 2002, the monthly premium is $54.00 a month. The premium amount is expected to increase in January 2003.

Payments for Part B services can be made by two methods: assignment and direct payment.

- Assignment Check to see if the conservatee's doctors will accept Medicare assignment. This means that doctors or suppliers will bill Medicare for their services, and Medicare will pay the doctor directly. It also means that the doctor accepts Medicare's *allowable charge* as full payment. Medical providers who accept an assignment of medical benefits are not allowed to charge the patient any amount over the allowable charge. Medicare will pay 80 percent, and the patient will pay the remaining 20 percent. The patient must pay any deductible and pay for any treatments not covered by Medicare.

- Direct payments When a doctor doesn't accept assignment, the patient pays the doctor or provider directly, and the doctor bills Medicare. Medicare sends the benefit check to the patient, not the doctor. Medicare pays 80 percent of an allowable charge, and the patient is responsible for the remaining 20 percent as well as any amount the provider charges above what Medicare considers the allowable charge.

Every Social Security office and many senior service centers have a list of Medicare participating doctors and health providers who will take assignment. You may also call 1-800-952-8627 in Northern California or 1-800-848-7713 in Southern California to ask about a particular provider.

The Social Security Administration publishes the *Guide to Medicare Coverage*, which is updated annually as changes in the law occur. This is automatically mailed to persons who are enrolled in Medicare. However, if the conservatee's mailing address has changed, you should contact the Social Security Administration to make sure that you continue to receive it for the conservatee. You should obtain this guide and make sure you also receive each year's updated edition.

Because Medicare's regulations change annually, and because the *Guide to Medicare Coverage* is available, this handbook does not provide greater coverage details. However, it is suggested that you become familiar with the service areas of Original Medicare, described in the preceding sections.

Important There are limits to most Medicare coverage. Even though certain coverage areas are mentioned here, don't assume that the conservatee will automatically be eligible for coverage. Eligibility for certain coverage depends on the type of illness or injury, the number of days of hospital care, the patient's medical needs after discharge from the hospital, and other factors.

Each time you make arrangements for any of the services described here for the conservatee, you should confirm what portion of the cost is expected to be covered by Medicare.

It is likely that Medicare will cover only *part* of the total cost. The patient is responsible for medical costs not covered by Medicare. If the conservatee has supplemental medical insurance, this may cover an additional portion of the cost.

Right to appeal Any action taken by Medicare regarding Part A or Part B benefits can be appealed. If you feel that Medicare has made an incorrect decision about a claim, you can file an appeal by following the instructions on the back of the determination form sent by Medicare, or you can ask your local Social Security Administration office for help. There may be other resources in your area that provide assistance with Medicare appeals. Also, some lawyers specialize in this field. L

C. Medicare + Choice Plans

A recent innovation in Medicare coverage is the availability in many areas of Medicare + Choice plans, under which the government contracts with private medical service providers. Some of the plans are managed care (HMO) type plans; others are fee-for-service plans, like Original Medicare. A person must be eligible for and enrolled in Original Medicare Parts A and B to be eligible to enroll in a Medicare + Choice plan. An eligible person may switch from one plan to another or back to Original Medicare, but there are restrictions, so if you are investigating a Medicare + Choice plan for your conservatee, you should be careful.

The details of Medicare + Choice plans are beyond the scope of this handbook. However, if you want to look into one of them for your conservatee, you can visit the Medicare Web site at *www.medicare.gov* and select "Medical Personal Plan Finder," or you can call 1-800-MEDICARE (1-800-633-4227) for more information. The government publication, *Medicare and You 2002,* has information on this subject, including comparison charts between the various kinds of plans available.

2. Medi-Cal

Medi-Cal is California's version of a combined federal and state program designed to help pay for medical care for people getting public assistance and other low-income people. It is referred to in federal law and in other states as Medicaid.

Although Medi-Cal recipients often also receive Medicare, these programs aren't related. Medicare is run by the Social Security Administration. Medi-Cal is administered by the State of California. Funding for Medi-Cal comes from federal Medicaid funds.

Eligibility There are several categories of individuals eligible to receive Medi-Cal:

- Supplemental Security Income (SSI) recipients Low-income people who are 65 or over, and blind or disabled people of any age who are receiving SSI aid payments, are automatically covered by Medi-Cal. It is important to apply for SSI whenever you can, even if the conservatee is eligible only for a small cash benefit, because Medi-Cal coverage comes with SSI.

- Temporary Aid for Needy Families (TANF, formerly Aid to Families with Dependent Children, or AFDC) People who are receiving benefits under the TANF program are automatically eligible for Medi-Cal.

- Medically Needy (MN) People who are 65 or over, or blind or disabled, and who aren't getting SSI may be eligible for Medi-Cal if they have very limited financial resources. If paying medical bills would leave the person with less money than Medi-Cal considers enough to live on, the patient has to pay part of the bills, and Medi-Cal will pay part.

- Nursing home residents People in nursing homes are eligible if their income and financial resources are within Medi-Cal limits.

Transferring assets to be eligible for Medi-Cal Under certain circumstances, assets can be spent down or transferred to others until they are down to the Medi-Cal eligibility limit. The conservatee may then become eligible for Medi-Cal.

This is an extremely complex and rapidly changing area of Medi-Cal regulations. You should not transfer assets until you have consulted with your lawyer. **L**

Expenses covered by Medi-Cal Medi-Cal pays for health care services that Medi-Cal considers to be medically necessary.

Some of these services must be authorized by Medi-Cal in advance. If so, the health care provider makes the request. The patient has the right to receive a copy of Medi-Cal's form denying coverage. Prior approval is not required for emergency care, necessary doctor's visits, or most drugs. You have the right to request a hearing if you believe that the authorization is unreasonably delayed or if it is denied.

Sometimes the patient may have to make a co-payment for prescription drugs or for nonemergency treatment that was given in an emergency room.

Claims on a deceased conservatee's estate The state has the right to place a claim on the estate of a deceased Medi-Cal recipient for Medi-Cal services received after the age of 55 and for long-term care received at any age. The state must waive the claim if payment of the claim would cause the decedent's dependents, heirs, or survivors substantial hardship.

Medi-Cal providers It is important to find out before treatment whether the conservatee's doctors and other health care providers accept Medi-Cal. Not all hospitals, nursing homes, and other health care providers accept Medi-Cal. However, *if Medi-Cal is accepted, the provider must accept the Medi-Cal reimbursement as payment in full.*

Nursing home care For nursing home care to be covered by Medi-Cal, the patient must have been admitted on a doctor's order, and the stay must be considered by Medi-Cal to be medically necessary. Medi-Cal recipients in nursing homes may keep a personal-needs allowance, and the rest of their income is paid to the nursing home.

A person in a nursing home who is on Medi-Cal and who owns a home continues to be eligible so long as

- He or she intends to return home, and
- The person's spouse or dependents are living in the home, or
- Certain other persons with relationships to the person are residing in the home, and the circumstances meet Medi-Cal's exemption guidelines.

Anyone, no matter how ill, can intend to return home. The patient's intent to return home should be stated on the application for long-term Medi-Cal care.

Special rules for couples when one spouse enters a nursing home When one spouse goes into a nursing home, the other spouse doesn't have to use up all of the couple's income and assets before Medi-Cal will help pay for nursing home care. Medi-Cal regulations about such situations can be complicated. Also, they may change periodically. You should consult your lawyer and the local Medi-Cal office for current Medi-Cal regulations and information. L

Medi-Cal and Medicare For people on Medicare, Medi-Cal pays

- The deductible for medical benefits under Part A
- Part B premiums
- The yearly deductible and co-payments for medical benefits under Part B

If a person receives both Medi-Cal and Medicare, a doctor may not bill the patient directly and may not make the patient pay the 20 percent co-payment that Medicare patients pay.

How to apply for Medi-Cal It is important to plan ahead so that you know in which month the conservatee will be eligible for Medi-Cal. Consult your lawyer and contact the Medi-Cal office as soon as you believe that this time is approaching, because it takes time to process the application. Once the conservatee's income and assets have been checked and Medi-Cal is approved, the conservatee will be given a Medi-Cal card.

You may request up to three months of retroactive coverage, and, if approved, the conservatee will be covered for these months.

Right to appeal A person getting Medi-Cal has the right to appeal any decision by the welfare department regarding Medi-Cal eligibility. If you do not have a lawyer, contact your local legal aid office for assistance with Medi-Cal eligibility and service problems.

3. County Health Services

People between the ages of 21 and 65 who aren't blind or disabled and who have no dependent children are not eligible for Medi-Cal (except pregnant women, nursing home residents, and refugees). The county is responsible for providing medical care to people who are sick and unable to pay for medical treatment. Even in these cases, the county may send a bill or request a partial payment for the services. Contact the county health department to find out about services in your county.

4. Medicare Supplemental Health Insurance (Medigap)

Medigap is a type of private insurance, not the name of an insurance company or a government program. Medigap insurance is designed to pay the co-payments and deductibles required by Medicare. Generally, this type of insurance is available to people 65 and over who have both Medicare Parts A and B. When you evaluate Medigap policies, you should understand that they will not cover all of the conservatee's health care expenses that Medicare doesn't pay.

Medigap policies use the language of the Medicare program and base their coverage decisions on Medicare determinations. Therefore, if Medicare won't cover a treatment, it's likely that a Medigap policy won't cover it either. Medigap policies don't pay for custodial nursing home care.

Look at Medigap policies carefully Before buying a Medigap policy, review the policy's outline of coverage. You don't have to buy a policy to get an outline of coverage, but you probably won't be able to see the policy itself before you buy it. However, you are legally entitled to a 30-day free review period. If you decide to cancel the policy within the first 30 days, the insurance company must refund all premiums.

When you are thinking of buying Medigap insurance for the conservatee, follow these guidelines:

- Don't buy more than one Medigap policy.
- Consider a Medicare + Choice plan instead of a Medigap policy.
- See if there's a waiting period before the policy pays for medical conditions that the insured already had before signing up for the policy.
- Take your time. Don't let yourself be pressured into buying. Don't be taken in by misleading advertisements or an insurance agent's misleading statements.
- Know with whom you are dealing. Keep the name and address of the agent or the insurance company.
- Don't pay cash. Make your check or money order payable to the insurance company, not the agent.

- Contact the insurance company if you don't receive the policy or any refund promptly.

- Remember that people who are eligible for Medi-Cal don't need Medigap policies.

5. Long-Term Care Insurance

Long-term care insurance is not the same as Medigap insurance. It is a type of insurance that is designed to pay for skilled, intermediate, or custodial nursing home care. It also may offer some home health care benefits.

Most long-term care policies pay a fixed amount for each covered day. Normally, benefits are not designed to increase with inflation, but some policies do give increases.

After hospitalization, many people need custodial care, in a facility or at home. Since this care isn't covered by Medicare, to be of any real value a long-term care policy should cover custodial care. Read the policy carefully to make sure that it will cover custodial care, even when Medicare does not. It is a good idea to ask your lawyer to review the policy as well. L

Currently, Medicare and all private insurance payments combined pay only a small percentage of nursing home bills. Medi-Cal and patients themselves pick up most of the costs of nursing home care. Therefore, it is important to evaluate this type of insurance carefully to decide whether the benefits justify the premium.

6. Other Types of Insurance

There are many types of medical insurance in addition to those discussed previously. The following are examples of insurance policies or plans you may encounter.

A. Dread Disease Policies

Dread disease policies are designed to cover the costs of a lengthy hospital stay for a particular disease, usually cancer. These types of policies typically have exclusions, waiting periods, time limits, and a cap on benefits. People often have trouble collecting on these policies. Very few dread disease policies cover

nursing home stays or cancer-related illness. They are outlawed in many states, and many consumer groups consider them to be bad buys.

B. Indemnity Policies

Indemnity policies usually pay a specific amount of money for each day the insured is hospitalized. In most cases, the amount is a very small portion of the actual cost. These policies don't pay benefits for illnesses outside a hospital, and the benefits don't go up with inflation.

C. Group Health Insurance

Many people who would otherwise lose their group health insurance coverage because of unemployment, divorce, or the death or retirement of a spouse are able to keep their insurance an additional period of time by paying their own premiums.

If the conservatee has experienced one of the changes mentioned in the preceding paragraph, you should consult your lawyer, as well as the office that administers the group health insurance, to determine whether the conservatee may be able to continue receiving benefits. You and your lawyer will need to review the group policy and the conservatee's particular circumstances very carefully.

D. Health Maintenance Organizations (HMOs)

An HMO is a type of prepaid health care plan that provides specific services to its enrolled members. HMOs have doctors and health care facilities that provide all benefits covered by Medicare.

Usually, HMOs have a special contract with Medicare. Medicare pays the HMO a set amount each month for each Medicare member, and the member pays little or nothing for HMO services. Members of an HMO agree to put away their Medicare card and use only HMO doctors and facilities for all medical care unless it is an emergency. When the patient uses doctors and facilities outside the HMO for nonemergency care, the patient is responsible for the bill, not Medicare and not the HMO.

7. Sources of Assistance

The Health Insurance Counseling and Advocacy Program (HICAP) of the California Department of Aging offers elderly people free advice on health care insurance. See Appendix B, "How to Find and Use Community Resources," for information about contacting HICAP.

To complain about an insurance company, contact the California Department of Insurance, Policy Services Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013. If you have a problem with Blue Shield or a prepaid health plan, contact the Department of Managed Health Care, California HMO Help Center, 980 Ninth Street, Suite 500, Sacramento, CA 95814.